MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 2002

Principal Life Insurance Company
711 High Street
Des Moines, IA 50392-0220

NAIC Group Code 0332
NAIC Company Code 61271

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

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Lynn L. Zukus, AIE, FLMI

Independent Market Conduct Examiners
Contracting with

The Colorado Division of Insurance
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August 29, 2003

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Principal Life Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine Small Group Health Insurance. We examined the Company's records at its office located at 711 High Street, Des Moines, IA 50392-0220. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT
EXAMINATION REPORT
OF
PRINCIPAL LIFE INSURANCE COMPANY

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COMPANY PROFILE

Principal Life Insurance Company was incorporated in June 1879, as an assessment life insurance company under the name of Bankers Life Association and commenced business on September 2, 1879. In 1911 the Company was transformed into a mutual legal reserve life insurance Company and its name was changed to Bankers Life Company. In 1986 the name of the Company was changed to Principal Mutual Life Insurance Company. Effective July 1, 1998, Principal Mutual Life Insurance Company formed a mutual insurance holding company and converted to a stock life insurance company subsidiary with the name of Principal Life Insurance Company.

The Company is licensed in DC, Puerto Rico and all states. The Company is also licensed in the Dominion of Canada and the Canadian provinces of Alberta, British Columbia, Manitoba, Nova Scotia, Ontario, Quebec and Saskatchewan as well as being a licensed reinsurer in Mexico. Principal was licensed and began operations in Colorado on September 14, 1887.

The Company's Accident and Health direct written premium in Colorado for 2002 was $42,896,917, representing 1.89% of the market share. The Company's loss ratio in Colorado for 2002 was 56.31%.

Best's Insurance Reports – L/H, 2002 Edition assigned a Best's Rating of A+ (Superior) to Principal Life Insurance Company.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Principal Life Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to small group sickness and accident insurance laws. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

For the period under examination, the examiners included statutory citations and regulatory references related to small group insurance reform laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair Methods of Competition and Unfair or Deceptive Acts or Practices
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Regulation 1-1-7	Market Conduct Record Retention
New Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Repealed And Re-Promulgated Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
New Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans

Amended Regulation 4-6-3	Concerning Colorado Uninsurable Health Insurance Plan Standardized Notice Form and Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Amended Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Amended Regulation 4-6-8	Concerning Small Employer Health Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Booklet-Certificate Forms, Applications, Endorsements and Rider Forms.

FORM NUMBER	FORM NAME
GC 500 Series	Master Policy for: Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GH 100 Series	Master Certificate for: Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GC 800-2	Amendment Form
GC 801-1	Endorsement Form
GC 802	Amendment/Endorsement Continued Form
GP 39154-3	Group Risk Appraisal Questionnaire
GP 45604-1	Health Statement
GP 4200-4	Employer Enrollment and Waiver Form
GP 42001-1	Request for Refusal of Group Coverage
GP 45700-3	Employer Application Form
GP 48657-1	Employee Enrollment and Waiver Form

GP 47873	Declaration of Termination of Domestic Partnership
GP 47872	Declaration of Domestic Partnership/Enrollment Form Addendum
GC 5000 Series	Small Group Indemnity and PPO Plans
GH 100 (MGCT) CO Basic	Basic Indemnity Conversion Plan Certificate
GH 100 (MGCT) CO Standard	Standard Indemnity Conversion Plan Certificate
GH 100 (MGCT) CO Basic	Basic PPO Conversion Plan Certificate
GH 100 (MGCT) CO Standard	Standard PPO Conversion Plan Certificate
GP 39824-5	Individual Purchase Application for Conversion Plans

The most frequently sold small group plan in Colorado in 2002 was the GC 5000 Series under which both Indemnity and PPO plans were sold with the PPO version being the most frequently sold plan. This was the only policy form series sold in Colorado other than the Basic and Standard state mandated health plans

Rating

The examiners reviewed a systematically selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

For cases that were initially effective or renewed during the period from January 1, 2002 through December 31, 2002, the examiners used Audit Command Language (ACL) to systematically select 100 small group (50 new and 50 renewal business) application files. The Company did not write individual business in 2002. These files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations

For small group cases that terminated (cancelled or non-renewed) during the period under examination, the examiners used ACL to systematically select a sample of fifty (50) files. The population of ten (10) declined files was used as the sample. These files were reviewed to determine if the procedures used for cancellations, non-renewals and declinations were in compliance with Colorado insurance law and contractual obligations.

Claims

The examiners used ACL to systematically select samples of electronically received and non-electronically received small group claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL to systematically select samples of 100 paid claims and 100 denied claims that were reviewed for the Company's overall claims handling practices. These claims were all received during the examination period of January 1, 2002 through December 31, 2002.

Utilization Review

The Company was unable to provide electronic lists for all utilization review cases in 2002. They did provide a hard copy list for cases processed by Sloans Lake Managed Care and for cases processed by Principal Financial Insurance for the PHCS network during 2002. The Company indicated that there were no appeals of adverse determinations or reconsiderations of adverse determinations for Colorado in 2002. A manual sample selection was used with fifty (50) files selected from the Sloans Lake list and fifty (50) files selected from the Principal Financial Insurance list. Additionally, the examiners reviewed the Company's utilization management procedures and policies.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of thirty-one (31) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found four (4) areas of concern in their review of company operations and management. The following issues were identified:

    1. Failure to maintain an access plan for one network and failure to maintain a complete access plan for another network.

    2. Certifying and using forms that do not comply with Colorado insurance law.

    3. Failure to have Colorado Health Plan Description forms available for the Basic and Standard Health Benefit Plans.

    4. Failure to maintain certain records necessary for a market conduct examination.

    It is recommended that procedures be established to ensure that access plans, a separate document, with all required elements and provisions for each managed care network that the carrier offers in the state of Colorado are maintained. Additionally, it is recommended that the Company develop, implement, and monitor the necessary procedures to ensure that all forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the company and that Colorado Health Plan Description forms should be available for distribution for all small group plans offered as part of its marketing materials. All records necessary for market conduct examinations should be maintained as required by Colorado insurance law.

- **Policy Forms:** The examiners found twenty (20) areas of concern in their review of the basic and standard health benefit plans and the most frequently sold group policy forms in use during the year under examination. The following issues were identified:

1. Failure to reflect an accurate description of preexisting condition limitations in large group forms.

2. Failure of the forms to reflect a correct definition of a dependent.

3. Failure to reflect complete or correct provisions for continuation privileges in large group forms.

4. Failure to reflect a correct definition of a Business Group of One.

5. Failure to include seasonal employees in the definition of eligible employees.

6. Failure to reflect correct deductible provisions in the Basic and Standard Health Benefit Plans.

7. Failure of the Company's forms to disclose the existence and availability of an access plan.

8. Failure of the forms to reflect correct benefits for low-dose mammography and prostate cancer screening.

9. Failure of the forms to reflect correct information concerning the requirement to maintain an adequate PPO network.

10. Failure of the forms to reflect a correct definition of a small employer.

11. Failure of the forms to reflect correct information concerning participation requirements.

12. Failure to limit the "look-back period" for all medical information to five (5) years.

13. Failure to include a description of the independent external review procedures in or attached to the master policy and the booklet-certificate for the Basic and Standard Health Benefit Plans.

14. Failure of the forms to reflect correct small employer eligibility requirements.

15. Failure of the forms to reflect correct preventive service benefits.

16. Failure of the forms to reflect the correct coverage for therapies for congenital defects and birth abnormalities.

17. Failure of the forms to reflect a complete list of covered organ transplants. (This was prior issue E11 in the findings of the 1998 final examination report).

18. Failure of the forms to provide benefits for covered services based on a provider's status as a family member.

19. Failure of the forms to reflect correct benefits for inpatient well baby care.

20. Failure of the forms to reflect correct and complete coverage to be provided for home health and hospice care services.

    It is recommended that the Company review and revise all applicable policy forms to comply with Colorado insurance law.

- **Rating:** The examiners found one (1) area of concern in their review of the rates and associated required rate filings.

    1. Failure, in some cases, to use the rates filed with the Colorado Division of Insurance.

       It is recommended that the Company establish procedures to ensure that filed rates are used as of the effective date stated in its filings with the Colorado Division of Insurance.

- **Applications:** The examiners found one (1) area of concern in their review of application files for the examination period. The following issue was identified:

    1. Failure to display a correct disclosure statement concerning guaranteed issue on renewal notices.

    It is recommended that the Company establish procedures to ensure that correct and complete wording is used in the required guaranteed issue disclosure on its renewal notices, marketing materials, small employer application forms and on all written refusals to insure which are related to health coverage for a business group of one.

- **Cancellations/Non-Renewals/Declinations:** The examiners found two (2) areas of concern during the review of the cancellation/non-renewal/declination files. The following issues were identified:

    1. Failure to offer conversion coverage to eligible members of terminated groups. (This was prior issue H1 in the findings of the 1998 final examination report).

    2. Failure to, in some cases, issue Certificates of Creditable Coverage.

    It is recommended that the Company establish procedures to ensure that its written notice of termination is accompanied by a written explanation of the availability of the Standard and Basic Health Benefit Plans in all required instances and that Certificates of Creditable Coverage are issued in all cases.

- **Claims:** The examiners found three (3) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

    1. Failure, in some cases, to pay, deny or settle clean electronic claims within thirty (30) days, clean non-electronic claims within forty-five (45) days, and except where fraud is involved, all claims within ninety (90) days.

    2. Failure, in some instances, to process claims accurately.

    3. Failure, in some instances, to pay late payment penalties on claims.

    It is recommended that the Company establish procedures to ensure payment, denial or settlement within the time frames required by law, review its claim processing procedures for accuracy of payment and ensure that late payment penalties are paid in all required instances.

- **Utilization Review:** The examiners found no areas of concern in their review of utilization review procedures.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

PRINCIPAL LIFE INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Failure to maintain an access plan for one network and failure to maintain a complete access plan for another network.

Section 10-16-704(9), C.R.S., Network adequacy, states:

Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan *shall demonstrate the following*: [Emphasis added.]

(a.9) If the covered person has a pharmacy benefit, an adequate number of pharmacy providers within a reasonable distance, travel time, delivery time, or all three. Nothing in this paragraph (a.9) shall preclude the use of a retail or mail-order pharmacy provider.

(b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:

(II) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services;

(III) Timely referrals for access to specialty care

(IV) A process for expediting the referral process when indicated by medical condition; and

(V)(A) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

(B) A provision that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.

(c) The carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

(d) The carrier's quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

(e) The carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(f) The carrier's methods for determining the health care needs of covered persons, tracking and assessing clinical outcomes from network services, and evaluating consumer satisfaction with services provided;

(g) The carrier's method for informing covered persons of the plan's services and features, including but not limited to the following:

(I) The plan's grievance procedures, which shall be in conformance with division rules

concerning prompt investigation of health claims involving utilization review and grievance procedures;

(II) The extent to which specialty medical services, including physical therapy, occupational therapy, and rehabilitation services are available;

(III) The plan's process for choosing and changing network providers; and

(IV) The plan's procedures for providing and approving emergency and medical care;

(h) The carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

(i) The carrier's process for enabling covered persons to change primary care professionals;

(j) *The carrier's proposed plan for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner.* [Emphasis added.]

In response to the request for copies of the Company's access plans, the examiners were provided a document titled "Managed Care Accessibility Analysis", dated May 22, 2002, for Sloans Lake Managed Care PPO Network, four (4) pages from the Company's departmental (Medical Network Contracting) Administrative Manual and sample pages of an accessibility quarterly review conducted by Principal. These items do not appear to correspond to the requirements for an access plan document to be maintained and updated not less than annually and to demonstrate certain elements and contain certain provisions as reflected in Colorado insurance law. The Company provided a copy of the access plan for Private Healthcare Systems (PHCS) that contained thirteen (13) instances in which it was indicated that insert wording is to be provided by the carrier. The Company was asked to provide the insert wording for each of these instances and the wording was provided for all but two (2) of these instances, items eleven (11) and thirteen (13). The wording in the access plan for these two (2) items is:

- **Carrier insolvency or cessation of operations C.R.S. §10-16-704(9)(j)**
  [Carrier inserts process for providing continuity of care in the case of carrier insolvency or cessation of operations.]

- [Carrier insert (sic) process for notification of covered persons about provider termination, and carrier insolvency or cessation of operations.]

The Company indicated it did not have standardized inserts for items 11 and 13 and that it believed these items would be addressed by operation of law and therefore need not be the topic of an insert. This does not appear to correspond to the requirement of Colorado insurance law that access plans reflect at a minimum the requirements specifically listed in the statute for the benefit of any interested party upon request.

Recommendation No. 1:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that access plans are maintained with all required elements and provisions and updated not less than annually for each managed care network that the carrier offers as required by Colorado insurance law.

Issue A2: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1)(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company were in compliance with statutory mandates as evidenced by Issues E1 through E20.

Recommendation No. 2:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R. S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that evidence of coverage forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified by an officer of the Company, as required by Colorado insurance law.

Issue A3: Failure to have Colorado Health Plan Description Forms available for the Basic and Standard Health Benefit Plans.

Section 10-16-108.5(11), C.R.S., Fair marketing standards, states:

(a) Effective January 1, 1998, all carriers offering or providing health benefit plan coverage or medicare supplemental coverage shall make available a Colorado health benefit plan description form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer.

(d) A carrier shall provide a completed Colorado health benefit plan description form for each of its health benefit plans:

(II) As part of its marketing materials, to any person or employer who may be interested in purchasing or obtaining coverage under such a plan. This requirement shall include the provision of the form by the carrier to every employee who has the option of selecting such a plan during an employer's open enrollment period.

Amended Regulation 4-2-20, Concerning The Colorado Comprehensive Health Benefit Plan Description Form ,promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R.S., states:

Section 2. BASIS AND PURPOSE

The purpose of this regulation is to establish and implement rules concerning the format for, elements of, and issuance of a Colorado Health Benefit Plan Description Form, pursuant to Section 10-16-108.5(11)(b), C.R.S. As required by law, the form is designed to facilitate comparison of different health plans by persons interested in purchasing or obtaining coverage under a health benefit plan. As also required by law, this regulation sets out procedures for carriers to make available a Colorado Health Benefit Plan Description Form for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident or such resident's employer.

Section 4. RULES

A. Effective September 30, 1998, all carriers offering or providing health benefit plan coverage or medicare supplemental coverage shall make available a completed copy of the Colorado Health Plan Description Form shown in Appendix A for each policy, contract, and plan of health benefits that either covers a Colorado resident or is marketed to a Colorado resident of such resident's employer, except as provided in Part B of Section 4 of this regulation. …

E. Carriers shall provide a Colorado Health Plan Description Form as follows:

(1)(a) Automatically, as part of the health benefit plan description materials given to employees or members of a group, association or health care cooperative who

have the option of selecting such an employer-sponsored, group-sponsored, association-sponsored, or cooperative-sponsored plan when they initially become eligible for coverage and during an open enrollment period;

(b) Automatically within three (3) business days of a potential policyholder expressing interest in a particular plan (e.g., "I am interested in the Gold Plan, the $500 deductible PPO plan, your Medicare HMO plan with vision care coverage, etc., "or "I want to purchase your Plan 200,` $5 copay HMO plan, "etc);

In response to a request from the examiner for copies of Colorado Health Plan Description Forms for the state mandated health benefit plans, the Company has responded:

> We did not sell any CO state plans in 2002. Due to this reason, we do not have a Health Plan Description form for the state plans that was used in 2002.

Colorado insurance law requires carriers to actively market all of their small group plans to anyone who expresses an interest in purchasing a plan. Health Plan Description Forms must be provided for each of a carrier's plans as part of its marketing materials and/or upon request from someone interested in a plan. The purpose, as expressed in Colorado insurance law, of having the forms available to provide prior to a sale is so an interested person can compare the benefits of the different plans. Providing them after a sale does not serve this purpose nor is it in compliance with the requirements of Colorado insurance law.

Recommendation No. 3:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108.5, C.R.S., and Amended Regulation 4-2-20. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Colorado Health Plan Description Forms are available for distribution as part of its marketing materials for all small group plans as required by Colorado insurance law.

Issue A4: Failure to maintain certain records necessary for a market conduct examination.

Regulation 1-1-7, Market Conduct Record Retention, promulgated under the authority of Section 10-1-109, C.R.S., states:

III. Rule

B. Records Required For Market Conduct Purposes

1. Every insurer/carrier or related entity licensed to do business in this state shall maintain its books, records, documents and other business records so that the insurer's/carrier's or related entity's claims, rating, underwriting, marketing, complaint, and producer licensing records are readily available to the commissioner. Unless otherwise stated within this regulation, records shall be maintained for the current calendar year plus two calendar years.

During the review of the sample of Cancelled-Non-Renewed files, the Company indicated on twenty-four (24) of the fifty (50) files that they were unable to provide copies of Certificates of Creditable Coverage for these files terminated in 2002, as they had not been archived.

CANCELLED-NON/RENEWED FILES

Population	Sample Size	Number of Exceptions	Percentage to Population
316	50	24	48%

Recommendation No. 4:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 1-1-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all records necessary for a market conduct examination are maintained as required by Colorado insurance law.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to reflect an accurate description of preexisting condition limitations in large group forms.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(a)(I) If it is a group health benefit plan, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for *losses incurred more than six months following the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment.* [Emphasis added.]…

It appears that the Company's large group forms are not in compliance with Colorado insurance law as they do not reflect the wording that would allow the first day of the waiting period, if any, to be counted toward meeting the required six (6) months before preexisting conditions would be covered.

The wording on page 1 of PART IV – BENEFITS, is:

Article 3 – Exclusion Period

Benefits for Treatment or Service of an individual's Preexisting Condition will be excluded for a period of [six] [twelve] consecutive months after the effective date of the individual's insurance under this Group Policy; and then benefits will be payable only with respect to Treatment or Service received after the exclusion period.

Form Number	Form Name
GC 5027 A	Section E – Preexisting Condition Exclusion
GC 5027 B	Section E – Preexisting Condition Exclusion

Recommendation No. 5:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its large group forms to reflect an accurate description of preexisting condition limitations as required by Colorado insurance law.

Issue E2: Failure of the forms to reflect a correct definition of a dependent.

Section 10-16-102, C.R.S., Definitions, states:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and an unmarried child *of any age who is medically certified as disabled and dependent upon the parent.* [Emphasis added.]

The Company's large group forms do not appear to be in compliance with Colorado insurance law in that the definition of a dependent is more limited and incomplete than allowed in the following ways:

1. There is no requirement that a member's stepchild receive principal support from the member to qualify as a dependent.

2. There is neither an age requirement as to when the disability occurs for a disabled dependent nor a requirement of being insured under the policy when becoming disabled.

The wording on page 5 of the large group forms is:

> **Dependent Child; Dependent Children**
>
> b. A Member's stepchild, if that child:
> (2) receives principal support from the Member

The wording on page 2 of the large group forms is:

> **Developmentally Disabled or Physically Handicapped Children**
> **(1) Qualification**
>
> Medical Expense Insurance for a child may be *continued* after the child reaches the maximum age for Dependent Children as defined in PART I of this Group Policy, provided that: [Emphasis added.]
>
> the child is incapable of self-support as the result of a Developmental Disability or Physical Handicap *and became so before reaching the maximum age* and is dependent on the Member for primary support: [Emphasis added.]

The Company's Basic and Standard Health Benefit Plan Master Policy does not appear to be in compliance with Colorado insurance law in that the definition of a dependent is more limited than allowed in the following ways:

1. There is no requirement that a member's stepchild receive principal support from the member to qualify as a dependent.

2. There is no requirement that a member's stepchild be approved by the Company in writing to qualify as a dependent.

The wording on policy page GC 510 (SE) CO-3 is:

DEFINITIONS, PAGE 4

c. A Member's stepchild or foster child, if that child:

(2) receives principal support from the Member; and
(3) is approved by the Company in writing as a dependent;

The Company's Basic and Standard Health Benefit Plan Booklet-Certificate does not appear to be in compliance with Colorado insurance law in that the definition of a dependent is more limited than allowed in the following ways:

1. There is no requirement that a member's stepchild be approved by the Company in writing to qualify as a dependent.

The wording on booklet-certificate page GH 136 (SE) CO-3 is:

DEFINITIONS

Dependent means:

- your stepchildren or foster children, if We approve in writing, and in the case of a foster child, if the child lives with you; and

The Company's GC 5000 policy and booklet-certificate do not appear to be in compliance with Colorado insurance law in that the definition of a dependent is more limited than allowed in the following way:

1. There is no requirement that a member's stepchild receive principal support from the member to qualify as a dependent.

The wording on policy page GC 5002 SE-3 is:

DEFINITIONS, PAGE 5

[Dependent Child; Dependent Children]

b. A Member's stepchild, if that child:

(2) receives principal support from the Member.

The wording on booklet certificate page GH 136 A (SE) - 2 is:

DEFINITIONS, PAGE 5

- Your stepchild, if this child:
- receives principal support from you.

Form Number	Form Name
GC 5002-3	PART I - DEFINITIONS
GC 5009 CO-1	PART III – INDIVIDUAL REQUIREMENTS AND RIGHTS
GC 500 SE Series	Master Policy for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GH 100 (SE) - 1	Booklet - Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 6:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect a definition of a dependent that is in compliance with Colorado insurance law.

Issue E3: Failure to reflect complete or correct provisions for continuation privileges in large group forms.

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(1) Group sickness and accident insurance - conversion privileges

(b) Every group sickness and accident insurance policy included within the provisions of section 10-16-214 (1) shall contain a provision which permits every covered employee whose employment is terminated, if the policy remains in force for active employees of the employer, to elect to continue the coverage for himself and his dependents. Such provision shall conform to the requirements, where applicable, of subparagraph (XVII) of paragraph (d) and paragraphs (e) and (f) of this subsection (1).

(XIX) The employer shall not be required to offer continuation of coverage of any person if such person is *covered* by medicare, Title XVIII of the federal "Social Security Act", or medicaid, Title XIX of the federal "Social Security Act". [Emphasis added.]

(e)(III) The employee shall notify the employer in writing of the employee's election to continue coverage, and shall make proper payment to the employer as soon as possible upon notification by the employer of termination; however, in no case shall such notification occur or such payment be made more than thirty days after the date of termination of employment unless the employer has failed to give timely notice in accordance with subparagraph (II) of this paragraph (e). …

(IV) If the employer fails to notify an eligible employee of the right to elect to continue the coverage, the employee shall have the option to retain coverage if, within sixty days of the date the employment is terminated, the employee makes the proper payment to the employer to provide continuous coverage.

The statements reflected in the large group certificate forms do not appear to comply with Colorado insurance law for continuation of coverage in the following instances:

- Stating that the Company is not required to offer continuation coverage to a person who qualifies for Medicare or Medicaid. Colorado insurance law states that insureds may be refused only if they are covered by Medicare or Medicaid.
- There is nothing reflected concerning the requirement of the employee to give written notice and pay the first month's premium within thirty (30) days after the date of termination of employment unless the employer has failed to give timely notice.
- There is nothing reflected concerning the sixty (60) days from termination to be allowed to elect continuation, if the employee does not receive proper notice.

The wording on page 4 of Part III – Individual Requirements And Rights is:

Article 3 – State Required – Colorado

b. **Qualification for Continuation**

A Qualified Person who would lose insurance under this Group Policy because of a Qualifying event may elect to continue the insurance if, on the date insurance would otherwise cease:

(2) The Qualified Person does not qualify for Medicare or Medicaid;

Form Number	Form Name
GC 5009 CO-1	PART III – Section D –Continuation

Recommendation No. 7:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its large group forms to reflect completely and correctly the provisions for continuation privileges as required by Colorado insurance law.

Issue E4: Failure to reflect a correct definition of a Business Group of One.

Section 10-16-102, C.R.S., **Definitions**, states:

(6)(a) "Business group of one" means, for purposes of qualification, an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company,` or partnership *who works twenty-four hours or more a week on a permanent basis* and who has carried on significant business activity for a period of at least one year prior to application for coverage, has *gross income* as indicated on federal internal revenue service forms 1040, schedule C, F, or SE, or other forms recognized by the federal internal revenue service for income reporting purposes which generated *gross income* from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of the *most recent consecutive three-year period*. [Emphases added.] For the purposes of this subsection (6), "substantial part of such individual's income" means income derived from business activities of the business group of one that are sufficient to pay for annual health insurance premiums for the business group of one.

(b) "Business group of one" includes a full-time household employee who works twenty-four hours or more a week on a permanent basis as a household employee, if that employee has derived at least a substantial part of such employee's earned income for one year out of the preceding three-year period from household employment, and if the employee's employer, on at least fifty percent of the days in a normal work week during the preceding calendar quarter, employed at least one household employee.

(c) For purposes of determining whether an applicant meets the requirements of the definition set forth in this subsection (6), a carrier may require an applicant to submit to the carrier any of the following forms of documentation that is applicable to the applicant's current business or employment:

(I) Employment-related tax and withholding information, including, but not limited to, a federal internal revenue service form 1099; and

(II) Relevant portions of federal and state tax returns or a certification by an attorney or certified public accountant that federal and state tax returns have been filed as a business.

The Company's definition of a Business Group of One does not appear to be correct as required by Colorado insurance law in the following ways:

1. The definition does not include the requirement of working twenty-four hours or more a week for an individual, a sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or partnership.

2. The word "taxable income" has been substituted for the required "gross income" in the two places it appears in the definition.

3. The following wording, which does not appear in the statute, has been inserted in

the first paragraph of the definition: "which generated taxable income in one of the two previous years".

4. The following wording in the first paragraph of the definition is incorrect: "for one year out of any three-year period." The required wording is: "for one year out of the most recent consecutive three-year period."
5. For purposes of determining whether an applicant meets the requirements of the definition of a BGO1, a carrier may request certain tax and withholding information or certifications by an attorney or certified public accountant. Individuals cannot be required to certify to this in an affidavit signed under oath as is indicated in both paragraphs of this definition.

The wording on policy page GC 510 (SE) CO-3 and booklet-certificate page GH 136 (SE) CO-3 for the Basic and Standard Health Benefit Plans and policy page GC 5002 SE 3 and booklet-certificate page GH 136 A (SE) – 2 is:

DEFINITIONS, PAGE 1 (B&S Plans)
DEFINITIONS, PAGE 2 (GC 5000 Plans)

Business Group of One

"Business Group of One" means, for the purposes of initial qualification as a Small Employer, an individual, sole proprietor, or a single full-time employee of a subchapter S corporation, C corporation, nonprofit corporation, limited liability company, or a partnership, who has carried on a significant business activity for a period of at least one year prior to application for coverage, has taxable income as indicated of (sic) federal IRS forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue service for income reporting purposes, which generated taxable income in one of the two previous years or from which that individual, sole proprietor, or single full-time employee has derived at least a substantial part of such individual's income for one year out of any three-year period. An individual meeting this definition must so certify in an affidavit signed under oath.

"Business Group of One" also includes a full-time household employee who works 24 or more hours a week on a permanent basis as a household employee, if that employee has derived at least a substantial part of such employee's earned income for one year out of the preceding three-year period from household employment, and if the employee's employer, on at least 50% of the days in a normal work week during the preceding calendar quarter, employed at least one household employee. An individual meeting this definition must so certify in an affidavit signed under oath.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

GH 100 (SE) -1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 8:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its master policy and booklet-certificates for all affected plans to reflect a correct definition of a Business Group of One as required by Colorado insurance law.

Issue E5: Failure to include seasonal employees in the definition of eligible employees.

Section 10-16-102, C.R.S., Definitions, states:

> (15)(a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.

Amended Regulation 4-6-8, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV), (1)(c)(l), and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, 10-16-214(1)(d), and 10-16-708, C.R.S., states:

> **Section 5. Issuance of Coverage**
>
> B. Determining Who is an Eligible Employee, Dependent
>
> (2) The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that employer defines its eligible employees (herein after referred to as "employer-determined eligible employees"). However, the initial offering made to all small employers by a small employer carrier shall be for coverage of all employees with a regular workweek of at least 24 hours. …

The Company's master policy and booklet certificate for Small Employer Plans, and the Small Employer Qualification Form appear to incorrectly limit the requirements to qualify as an eligible employee for small group coverage. Colorado insurance law does not exclude seasonal employees.

The wording in the small group policy and certificates is:

> **DEFINITIONS,**
>
> **Small Employer**
>
> NOTE: For the sole purpose of defining a Small Employer, the term "Eligible Employee" means any employee (other than a temporary or seasonal employee), regularly scheduled to work at least 24 hours a week. …

The wording on page 1 of the Small Employer Qualification Form is:

> **Small Employer Definition**
>
> For the sole purpose of defining a Small Employer, the term "Eligible Employee" means any employee (other than a part-time, temporary or *seasonal* employee), regularly scheduled to work at least 24 hours a week. …[Emphasis added.]

Form Number	Form Name	
GC 500 SE Series	Master Policy for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan	
GH 100 (SE) -1	Booklet-Certificate for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan	
GC 5000 Series	Group Medical Expense Insurance	
Small Employer Qualification – CO	GP 38286-8 GP 38286-7	11/2000 06 1999 MIHC

Recommendation No. 9:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. and Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to indicate that seasonal employees are eligible for coverage as required by Colorado insurance law.

Issue E6: Failure to reflect correct deductible provisions in the Basic and Standard Health Benefit Plans.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states:

III. Rules

A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2002

2002 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO
2002 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

Benefit Grid

PART B: SUMMARY OF BENEFITS

BASIC
INDEMNITY PLAN

4. ANNUAL DEDUCTIBLE	
a) Individual	$1,000
b) Family	$3,000

STANDARD
INDEMNITY PLAN

4. ANUAL DEDUCTIBLE	
a) Individual	$ 500
b) Family	$1,500

BASIC PREFERRED PROVIDER PLAN

	IN-NETWORK	OUT-OF-NETWORK[1a]
4. ANNUAL DEDUCTIBLE		Deductibles are separate from in-network deductibles
a) Individual	$750	$1,500
b) Family	$2,250	$4,500

STANDARD PREFERRED PROVIDER PLAN

	IN-NETWORK	OUT-OF-NETWORK[1a]
4. ANNUAL DEDUCTIBLE		Deductibles are separate from in-network deductibles
a) Individual	$300	$ 600
b) Family	$900	$1,800

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans reflect a statement concerning a deductible for each hospital admission that does not apply to the state mandated Indemnity and PPO Plans. There is no separate deductible amount for an inpatient hospital confinement in these plans, only an annual deductible for individuals and an annual deductible for a family that would be applied to all services until it is satisfied.

The wording on page 9 (Policy) and page 7 (Booklet-Certificate) is:

GC 510 (SE) CO-3

DEFINITIONS

[Period of Confinement

A period of Hospital confinement. For the purposes of applying the Hospital charges deductible amount for each admission, two or more periods of Hospital confinement will be considered one period of confinement unless caused by an unrelated sickness of (sic) injury, or unless separated by three months or more.]

GH 136 (SE) CO-3

DEFINITIONS

[Period of Confinement means a period of hospital confinement. For the purposes of applying the Hospital charges deductible amount for each admission, two or more periods of Hospital confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by three months or more.]

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Standard Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE) - 1	Booklet - Certificate for the Basic Indemnity Health Benefit Plan Standard Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard PPO Health Benefit Plan

Recommendation No. 10:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its master policy and booklet-certificate for the Basic and Standard Health Benefit Plans to reflect correct deductible provisions as required by Colorado insurance law.

Issue E7: Failure of the Company's forms to disclose the existence and availability of an access plan.

Section 10-16-704(9), C.R.S., Network adequacy, states:

> Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204(3), C.R.S., available on its business premises and shall provide them to any interested party upon request. *In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan*. [Emphasis added.] All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan shall demonstrate the following:

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans and its GC 5000 Series plans do not disclose the existence and availability of an access plan as required by Colorado insurance law.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic PPO Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE) - 1	Booklet-Certificate for the Basic PPO Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 11:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to disclose the existence and availability of an access plan as required by Colorado insurance law.

Issue E8: Failure of the forms to reflect correct benefits for low-dose mammography and prostate cancer screening.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (4)(a) … All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women. Routine and diagnostic screenings provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and shall not be subject to policy deductibles. *Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index*. [Emphasis added.] Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. …
>
> (b) The requirements of this section shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after July 1, 1995, and to all group accident and sickness policies and group health care service or indemnity contracts issued, renewed, or reinstated after July 1, 1995.
>
> (10) **Prostate cancer screening.**
> (a) …Such coverage *shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening*. …[Emphasis added.]

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans and the policy and booklet-certificate for the GC 5000 Series plans do not appear to reflect correct benefits for the mandated low-dose mammography and prostate cancer screening as required by Colorado insurance law. The low-dose mammography benefit is required to be the lesser of a specified amount (adjusted annually to reflect increases or decreases in the consumer price index), per mammography screening or the actual charge for such screening. This does not correspond to a prevailing geographic area charge amount determined by the Company. This minimum mammography amount is adjusted on September 1 of each year, and from September 1, 2001 through August 31, 2002, the minimum benefit was $75.62. Effective September 1, 2002 the minimum benefit increased to $76.60. The prostate cancer screening benefit is required to be the lesser of sixty-five dollars ($65.00) or the actual charge for such screening. This does not correspond to a prevailing geographic area charge determined by the Company. The only place that coverage for these two (2) benefits is mentioned is in the "Preventive Care Services" section of the policy.

The wording on page 11 (policy) and page 8 (certificate-booklet) is:

GC 510 (SE) CO-3 (policy)
GH 136 (SE) CO-3 (booklet-certificate)

DEFINITIONS

Prevailing Charges

The amount, as determined by the Company, that most health care providers within a geographic cost area charge for a treatment or service.

Prevailing Charges means the amount, as determined by Us, that most health care providers within a geographic cost area charge for a treatment or service.

The wording on pages **GC 552 (SE) CO-5** (policy) is:

PART IV – BENEFITS

Section B – Comprehensive Medical Expense Insurance
Pages 5 and 6 – Basic and Standard Indemnity

Article 1B – Payment Conditions – Preventive Care Services

Comprehensive Medical Covered Charges will include charges for Preventive Care services as described below. Benefits will be payable at 100% of Covered Charges in excess of the $10 per visit copayment described in Article 2 of this section. *Members or Dependents will also be responsible for payment of charges that exceed Prevailing Charges for the treatment or service provided.* [Emphasis added.]

Section B – Comprehensive Medical Expense Insurance
Page 1 – Basic and Standard PPO's
Article 1 – Payment Conditions

If a Member or Dependent is sick or injured, the company will pay the charges for any treatment or service that is listed in this section under Covered Charges, but the benefits payable for all listed treatment or service received during a calendar year will not be more than:

a. Preferred Providers

If medical care is received from Preferred Providers, Comprehensive Medical benefits payable for medical care received each calendar year will be:

(3) for confinement, treatment, or service listed under Category D, 100% of each person's Covered Charges in excess of the applicable copayment amount:

Article 3 – Covered Charges
Page 8 – Basic and Standard PPO's

Covered Charges will be the actual cost charged to the Member or Dependent for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Page 11 – Basic PPO
Page 10 – Standard PPO

d. **Category D** includes the following Preventive Care services:

The wording on page **GH 102 (SE) CO-4** (booklet-certificate) is:

Summary of Benefits - Comprehensive Medical
Page 5 - Basic and Standard Indemnity

Benefits payable - Preventive Care

Benefits are payable for the following Preventive Care services at 100% of Covered Charges in excess of the $10 per visit copayment described below. *You will also be responsible for payment of charges that exceed Prevailing Charges for the treatment or service provided.* [Emphasis added.]

The wording on page **GH 402 (SE) CO-5** (booklet-certificate) is:

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL
Page 1 - Basic and Standard PPO's
Covered Charges

Covered Charges will be the actual cost charged to you or one of your Dependents for Medically Necessary Care, but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Page 4 - Basic & Standard PPO's

Category D includes the following Preventive Care services:

The wording on the GC 5000 Series policy page GC 5002 SE-3 is:

PART I - DEFINITIONS, PAGES 13 & 14

Prevailing Charges

a. For medical care received from Preferred Providers, the amount based on the negotiated fee between the Preferred Provider and the PPO.

b. For medical care received from Non-Preferred Providers, the amount, as determined by The Principal, that most health care providers charge within a geographic cost area for a Treatment or Service.

For the purpose of coverage provided under this Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by The Principal, [75%] or more of all other charges reported to The Principal for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

The wording on the GC 5000 Series policy page GC 5012-2 is:

PART IV – BENEFITS

Section A – Medical Expense Insurance (General Provisions), Page 3

Article 3B – Benefits Payable – State Required – Colorado

Subject to the benefits payable provisions, as described in Article 3 above, benefits will be payable for:

a. Mammography Services

Covered Charges will include charges incurred by a Member or Dependent for mammography services. Benefits will be payable at 100% of Prevailing Charges. No Deductible or Copay will be applied to these services. Benefits will be determined on a [calendar year] [policy year] basis.

b. Routine Screening for Early Detection of Prostate Cancer
Covered Charges will include charges incurred by a Member or Dependent for an annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories. Benefits will be payable at 100% of Prevailing Charges. No Deductible or Copay will be applied to these services.

The wording on the GC 5000 Series booklet certificate page GH 136 A (SE) – 2 is:

DEFINITIONS, PAGE 11

[Prevailing Charges means:

- As determined by Us, the amount that most healthcare providers charge within a geographic cost area for a Treatment or Service.

For purposes of coverage provided under the Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by Us, [80%] or more of all other charges reported to Us for the same (or a similar) Treatment of Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

The wording on the GC 5000 Series booklet-certificate page GH 401 A – 2 is:

Benefits Payable – State Required – Colorado

Subject to the benefits payable provisions, as described above, benefits will be payable for:

- **Mammography Services**

  Covered Charges will include charges incurred by you or one of your Dependents for mammography services. Benefits will be payable at 100% of Prevailing Charges. No Deductible or Copay will be applied to these services. Benefits will be determined on a [calendar year] [policy year] basis.

- **Routine Screening for Early Detection of Prostate Cancer**

  Covered Charges will include charges incurred by you or one of your Dependents for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories. Benefits will be payable at 100% of Prevailing Charges. No Deductible of Copay will be applied to these services.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE) -1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 12:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct benefits for low-dose mammography and prostate cancer screening as required by Colorado insurance law.

Issue E9: Failure of the forms to reflect correct information concerning the requirement to maintain an adequate PPO network.

Section 10-16-704, C.R.S., Network adequacy, states:

(1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. …

(2)(a) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and *ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.* [Emphasis added.]

(2.7)(b) Nothing in subparagraph (I) of paragraph (b) of subsection (2) of this section shall exempt a carrier from having a participating provider for all covered benefits. *In any case where the carrier has no participating providers to provide a covered benefit, the provisions of paragraph (a) of subsection (2) of this section shall apply.* [Emphasis added.]

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans, and GC 5000 Series policy indicate the Company has the right to terminate the Preferred Provider Organization portion of the policy if the Company or the Preferred Provider Organization terminates the arrangement, and in this situation to pay the "Other Than Preferred Providers" level of benefits.

Colorado insurance law requires that a managed care network be maintained with a sufficient number of providers to assure that all covered benefits are accessible without unreasonable delay. In addition, the law requires the carrier to ensure that in any case where the carrier has no participating providers to provide the covered benefit, that it is obtained at no greater cost to the covered person than if the benefit were obtained from a participating provider.

The wording on page 10 of the policy is:

DEFINITIONS

[Preferred Provider]
GC 510 (SE) CO-3

The Company has the right to terminate the Preferred Provider Organization (PPO) portion of this policy if the Company or the Preferred Provider Organization (PPO) terminates the arrangement. In the event of termination, the Company will pay the level of benefits as described in this policy for medical care received from "Other Than Preferred Providers". In addition, the Company will assume responsibility for assisting the insured person with the Hospital Preadmission Authorization and Presurgery Review requirements described in PART IV, Section B (1C) of this policy under the heading "Cost Containment Requirements".

The wording on page 1 of the booklet-certificate is:

SUMMARY OF BENEFITS

Preferred Provider Organization (PPO)
GH 102 (SE) (CO-4

We have the right to terminate the PPO portion of this plan if We or the PPO terminate the arrangement. In the event of termination, We will pay the level of benefits as described for medical care received from "Other Than Preferred Providers." In addition, We will assume responsibility for assisting you and your Dependents with the Hospital Preadmission Authorization and Presurgery Review requirements described under the heading "Utilization Management Requirements."

The wording on policy page GC 5002 SE-3, is:

DEFINITIONS, PAGE 13

[Preferred Provider/PPO Provider

The Principal has the right to terminate the preferred provider organization (PPO) portion of this Group Policy if The Principal or the preferred provider organization (PPO) terminates the arrangement.

The wording on booklet certificate page GH 136 A (SE) – 2 is:

DEFINITIONS, PAGE 11

[Preferred Provider/PPO Provider]

We have the right to terminate the PPO portion of the Group Policy if We or the PPO terminates the arrangement.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GH 100 (SE) - 1	Booklet-Certificate for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 13:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct information concerning maintenance of an adequate PPO network as required by Colorado insurance law.

Issue E10: Failure of the forms to reflect a correct definition of a small employer.

Section 10-16-102, C.R.S., Definitions, states:

> (40) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. On and after January 1, 1996, "small employer" includes a business group of one. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans and the policy and booklet-certificate for the GC 5000 Series plans appear to reflect an incorrect definition of a "Small Employer" in the following ways:

Uses only the wording "an employer" instead of "any person, firm, corporation, partnership, or association" actively engaged in business.

Does not reflect that an employer qualifies with having eligible employees on only fifty percent of the working days during the preceding calendar quarter.

Does not reflect that for qualification purposes, the majority of the employees should be employed within the state of Colorado.

Does not reflect that the business cannot have been formed primarily for the purpose of purchasing insurance.

Reflects that the business days to have no more than fifty eligible employees for qualification purposes is for the preceding calendar <u>year</u> instead of the preceding calendar <u>quarter</u>.

The wording on page 11 of the policy and page 9 of the booklet-certificate is:

DEFINITIONS
GC 510 (SE) CO-3
GH 136 (SE) CO-3

Small Employer

An employer actively engaged in business that employs an average of at least two but not more than 50 Eligible Employees on business days during the preceding calendar year and that employs at least two Eligible Employees on the Date of Issue of this policy and on each subsequent Policy Anniversary. "Small Employer" also includes a Business Group of One, as defined in this PART I.

In determining the number of Eligible Employees, the following rules apply:

b. If an employer was not in existence throughout the preceding calendar year, determination will be based on the average number of Eligible employees that the employer reasonably expects to employ on business days in the current calendar year.

The wording on policy page GC5002 SE-3 is:

PART I – DEFINITIONS, PAGE 15

Small Employer

An employer actively engaged in business that employs an average of at least two but not more than 50 Eligible Employees on business days during the preceding calendar year, and that employs at least two Eligible Employees on the Date of Issue of this Group Policy and on each subsequent Policy Anniversary. In order to be classified as a Small Employer with more than one employee when only one employee enrolls in the Small Employer's health plan, the Small Employer must submit to The Principal the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees. Such employer must also meet the [Policyholder] [Participating Unit] Eligibility Requirements of PART II, Section A. "Small Employer" also includes a Business Group of One, as defined in this Part I.

In determining the number of Eligible Employees, the following rules apply:

b. If an employer was not in existence throughout the preceding calendar year, determination will be based on the average number of Eligible employees that the employer reasonably expects to employ on business days in the current calendar year.

The wording on booklet-certificate page GH 136 A (SE) – 2 is:

DEFINITIONS, PAGES 12 & 13

Small Employer means an employer actively engaged in business, that employs an average of at least two but not more than 50 Eligible Employees on business days during the preceding calendar year, and that employs at least two Eligible Employees on the Date of Issue of the Group Policy and on each subsequent Policy Anniversary. In order to be classified as a Small Employer with more than one employee when only one employee enrolls in the Small Employer's health plan, the Small Employer must submit to US the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees. "Small Employer" also includes a Business Group of One, as defined in this section.

In determining the number of Eligible Employees, the following rules may apply:

If an employer was not in existence throughout the preceding calendar year, determination will be based on the average number of Eligible Employees that the employer reasonably expects to employ on business days in the current calendar year.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GH 100 (SE) - 1	Booklet-Certificate for the Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 14:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect a correct definition of a small employer as required by Colorado insurance law.

Issue E11: Failure of the forms to reflect correct information concerning participation requirements.

Section 10-16-105(7.4), C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

(a) Except as provided in paragraph (d) of this subsection (7.4), the requirements used by a small employer carrier to determine whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states:

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V. All basic and standard health benefit plans shall also comply with the following requirements:

I. **Participation Requirement** – The maximum participation requirement shall be seventy-five percent (75%) of eligible employees who are not covered by existing creditable group coverage.

The Company's master policy for the Basic and Standard Health Benefit Plans, the GC 5000 Series policy, and an Employee Enrollment & Waiver Form do not appear to be in compliance with Colorado insurance law in that they require all eligible employees to enroll if the employer pays all of the premium.

Colorado law allows a small employer carrier to vary minimum participation requirements only by the size of the small employer group, and to apply that requirement uniformly among all small employers with the same number of eligible employees. The percentage of premium paid by the employer is not an allowable reason for variance of participation. Additionally, the maximum participation requirement for a small employer is 75% of eligible employees.

The wording on page 2 of the master policy for the Basic and Standard Health Benefits Plans and the GC 5000 Series policy is:

PART II – POLICY ADMINISTRATION

Section A – Contract, Page 2

d. If the Member is to contribute no part of the premium, 100% of Eligible Employees must enroll.

The wording on page 1 of the Employee Enrollment & Waiver Form is:

BENEFIT OPTIONS (You cannot decline any coverage paid in full by your employer.)

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance
GP 48657-1	Employee Enrollment & Waiver - CO

Recommendation No. 15:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S. and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct information concerning participation requirements as required by Colorado insurance law.

Issue E12: Failure to limit the "look-back period" for all medical information to five (5) years.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

> (7) An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to the provisions of this section shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years from the date of application. …

The Company's "Health Statement – Co" form reflects a request for medical information that does not appear to be in compliance with Colorado insurance law that limits a "look-back period" for medical information to five (5) years from the date of application.

The wording on page 2 of the form is:

> Health Information for All coverages Being Applied for
>
> 4. yes no **In the past 10 years,** has any person on whom coverage is requested been treated for, diagnosed as having or tested positive for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or any other immune disorder?

Form Number	Form Name
GP 456-4-1	Health Statement - CO

Recommendation No. 16:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect only a five (5) year "look-back period" as required by Colorado insurance law.

Issue E13: Failure to include a description of the independent external review procedures in or attached to the master policy and booklet-certificate for the Basic and Standard Health Benefit Plans.

Section 10-16-113.5, C.R.S., Independent external review of benefit denials – legislative declaration – definitions, states:

> (6) All health coverage plan materials dealing with the plan's grievance procedures shall advise covered persons in writing of the availability of an independent external review process, the circumstances under which a covered individual requesting an independent external review may use the independent external review process, the procedures for requesting an independent external review, and the deadlines associated with an independent external review.

New Regulation 4-2-21, External Review of Benefit Denials of Health Coverage Plans, promulgated and adopted by the commissioner of Insurance under the authority of § 10-1-109, 10-16-109, 10-16-113(3)(b) and 10-16-113.5(4)(d), C.R.S., states:

> **Section 5. Notice and Disclosure of Right to External Review**
>
> B. (1) Effective for policies issued or renewed on or after June 1, 2000, each carrier shall include a description of the external review procedures in or attached to all health coverage plan materials dealing with the plan's grievance procedures including but not limited to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.
>
> (2) The description required under (1) of this Subsection B shall include a notification of the availability of an external review process, the circumstances under which a covered person may use the external review process, the procedures for requesting an external review, and the timelines associated with an external review.

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans do not include a description of the independent external review procedures in or attached to them as required by Colorado insurance law.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

Recommendation No. 17:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-113.5, C.R.S. and New Regulation 4-2-21. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to include a description of the external review procedures in or attached to the health coverage plan materials as required by Colorado insurance law.

Issue E14: Failure of the forms to reflect correct small employer eligibility requirements.

Section 10-8-601.5, C.R.S., Applicability and scope, states:

> (4) Notwithstanding any provision of law to the contrary, a carrier may decline to renew or reenroll a business group of one that has been terminated by the carrier for non-payment of premiums. The time period during which the carrier may so decline shall extend for up to six months after the date of termination or until the next open enrollment period, whichever is greater.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states:

> (7.3)(a) Except as otherwise provided in this subsection (7.3), effective January 1, 1995, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to such small employers the choice of a basic health benefit plan or a standard health benefit plan. Effective July 1, 1997, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Colorado; …

The Company's master policy for the Basic and Standard Health Benefit Plans and the policy for the GC 5000 Series plans, reflect a small employer eligibility requirement that does not appear to be in compliance with Colorado insurance law. There is no provision in Colorado insurance law to allow a carrier to decline coverage to a small employer for twelve (12) months after the date of termination if coverage was terminated due to any of the conditions listed in the policy. The one exception is that business groups of one that have been terminated for non-payment of premiums can be declined for renewal or reenrollment for the greater of six months after termination or until the next open enrollment period.

The wording on the master policy page GC 514 (SE) CO-2 is:

> **PART II – POLICY ADMINISTRATION**
>
> **Section A – Contract**
> **Article 3 – Policyholder Eligibility Requirements**
>
> If a Policyholder had prior coverage with the Company which coverage terminated due to nonpayment of premium, fraud or misrepresentation of material fact, or failure to comply with minimum participation or employer-contribution requirements, the Company will not accept application from that Policyholder within 12 months after the date of such termination.

The wording on the policy page GC 5003 SE-3 is:

> **PART II – POLICY ADMINISTRATION**
>
> **Section A – Contract, Page 2**
> **Article 3 – [Policyholder] [Participating Unit] Eligibility Requirements**

If a [Policyholder] [Participating Unit] had prior coverage with The Principal which coverage terminated due to nonpayment of premium, fraud or misrepresentation of material fact, or failure to comply with minimum participation or employer-contribution requirements, The Principal will not accept application from that [Policyholder] [Participating Unit] within 12 months after the date of such termination.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 18:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-8-601.5 and 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect only correct policyholder eligibility requirements as required by Colorado insurance law.

Issue E15: Failure of the forms to reflect correct preventive service benefits.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states:

III. Rules

A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

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I. The basic health benefit plan for an indemnity, preferred provider, and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan."

2002 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO
2002 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO
Benefit Grid

Footnote 6 See Attachment 1 for list of covered preventive services.

Attachment 1

Covered Preventive Services	
Age 40-64	Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75
Age 65 and older	Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans do not appear to reflect correct preventive services benefits in that the upper age limit reflected for annual fecal occult blood testing (hemocults) is 70 instead of 75.

The wording on policy page 6 (Basic Indemnity), pages 5 and 6 (Standard Indemnity), pages 11 and 12 (Basic PPO) and page 11 (Standard PPO) is:

PART IV – BENEFITS

GC 552 (SE) CO-5 **Basic & Standard Indemnity and Basic PPO**
GC 552 (SE) CO-4 **Standard PPO**

Section B – Comprehensive Medical Expense Insurance

Ages 40 – 64	Either annual hemocults or 2 colorectal visualizations between ages 50 and 70
Ages 65 and older	2 colorectal visualizations between ages 50 and 70

The wording on booklet-certificate page 6 (Basic and Standard Indemnity) and page 5 (Basic and Standard PPO) is

Summary of Benefits:
Comprehensive Medical Expense Insurance

GH 102 (SE) CO-4 **Basic and Standard Indemnity**
GH 402 (SE) CO-5 **Basic and Standard PPO**

Benefits Payable – **Preventive Care**

Ages 40 – 64	Either annual hemocults or 2 colorectal visualizations between ages 50 and 70
Ages 65 and older	2 Colorectal visualizations between ages 50 and 70

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan

Basic PPO Health Benefit Plan
Standard Indemnity Health Benefit Plan
Standard PPO Health Benefit Plan

Recommendation No. 19:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct benefits for preventive services as required by Colorado insurance law.

Issue E16: Failure of the forms to reflect correct coverage of therapies for congenital defects and birth abnormalities.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(1.7) Therapies for congenital defects and birth abnormalities

(a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.

(b) The level of benefits required in paragraph (a) of this subsection (1.7) shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and *without regard to whether the purpose of the therapy is to maintain or to improve functional capacity*. [Emphasis added.]

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans and the policy and booklet-certificate for the GC 5000 Series plans do not reflect that mandated therapies for congenital defects and birth abnormalities for covered children up to five years of age are to be provided without regard as to whether the purpose of the therapy is to maintain or to improve functional capacity. Additionally, the forms specifically state that benefits will not be paid for maintenance therapy after maximum medical improvement has been achieved. This does not appear to be in compliance with Colorado insurance law.

The wording in the master policy is:

PART IV – BENEFITS

Section A – Medical Expense Insurance (General Provisions)

(Basic Health Care Plan)
(Standard Health Care Plan)
GC 550 (SE)-4

b. Therapy for Congenital Defects and Birth Abnormalities

Covered Charges will include Medically Necessary Care for physical, occupational, and speech therapy for treatment and service of congenital defects and birth abnormalities for a covered Dependent child up to five years of age. Benefits will be payable the same as for any other treatment or service up to a maximum of 20 visits per calendar year for each physical, occupational, and speech therapy.

Section B – Comprehensive Medical Expense Insurance

(Basic Health Care Plan)
(Standard Health Care Plan)

GC 552 (SE) CO-5

Article 3 – Covered Charges

Indemnity Plans and PPO Plans

physical, occupational and speech therapy only for medically necessary therapeutic treatment. Benefits will not be paid for maintenance therapy after maximum medical improvement has been achieved;

The wording in the booklet-certificate is:

(Basic Health Care Plan)
(Standard Health Care Plan)

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL EXPENSE COVERAGE

Benefits Payable – State Required – Colorado

- **Therapy for Congenital Defects and Birth Abnormalities**

  Covered Charges will include Medically Necessary Care for physical, occupational, and speech therapy for treatment and service of congenital defects and birth abnormalities for a covered Dependent child up to five years of age. Benefits will be payable the same as for any other treatment or service up to a maximum of 20 visits per calendar year for each physical, occupational, and speech therapy.

GH 402 (SE) CO-5

Covered Charges

Indemnity Plans and PPO Plans

- physical, occupational and speech therapy only for medically necessary therapeutic treatment. Benefits will not be paid for maintenance therapy after maximum medical improvement has been achieved;

The wording on the GC 5000 Series policy page GC 5012-2 is:

PART IV – BENEFITS

Section A – Medical Expense Insurance (General Provisions), Page 6

h. Therapy for Congenital Defects and Birth Abnormalities

Covered Charges will include Medically Necessary Care for physical, occupational, and speech therapy for the Treatment and Service of congenital defects and birth abnormalities for a covered Dependent Child up to five years of age. Benefits will be payable the same as for any other covered Treatment or Service up to a maximum of 20 visits per calendar year for each physical, occupation, (sic) and speech therapy.

The wording on the GC 5000 Series policy page GC 5013 CO-2 is:

PART IV – BENEFITS

Section B – Comprehensive Medical Expense Insurance, Page 30

Article 16 – Limitations

Covered Charges will not include and no benefits will be paid for:

yy. Treatment or Services for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained;

The wording on the GC 5000 Series booklet certificate page GH 401 B – 2 is:

DESCRIPTION OF BENEFITS
MEDICAL EXPENSE INSURANCE
(PAYMENT PROVISIONS)

Benefits Payable – State Required – Colorado

- Therapy for Congenital Defects and Birth Abnormalities

Covered Charges will include Medically Necessary Care for physical, occupational, and speech therapy for the Treatment and Service of congenital defects and birth abnormalities for a covered Dependent Child up to five years of age. Benefits will be payable the same as for any other covered Treatment or Service up to a maximum of 20 visits per calendar year for each physical, occupational, and speech therapy.

The wording on the GC 5000 Series booklet certificate page GH 407 B CO – 2 is:

DESCRIPTION OF BENEFITS

MEDICAL EXPENSE INSURANCE

Limitations

- Treatment or Services for maintenance therapy or supportive care or when maximum therapeutic benefit (no further objective improvement) has been attained;

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 20:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct coverage to be provided for therapy for congenital defects and birth abnormalities as required by Colorado insurance law.

Issue E17: Failure of the forms to reflect a complete list of covered organ transplants. (This was prior issue E11 in the findings of the 1998 final examination report).

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states:

III. Rules

A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

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2002 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

Benefit Grid

PART B: SUMMARY OF BENEFITS

	Basic Indemnity Plan Standard Indemnity Plan	Basic PPO Plan Standard PPO Plan
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, *lung*, cornea, kidney, *kidney/pancreas*, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. [Emphasis added.]	

22 Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans does not reflect a complete list of organ transplants to be covered. The "lung" and the "kidney/pancreas transplant" are not shown as covered transplants.

The wording on policy page 9 (Basic Indemnity), page 8 (Standard Indemnity), page 10 (Basic PPO) and pages 9 and 10 (Standard PPO) is:

PART IV – BENEFITS

Section B – Comprehensive Medical Expense Insurance

Article 3 – Covered Charges

GC 552 (SE) CO-5 Basic and Standard Indemnity and Basic PPO
GC 552 (SE) CO-4 Standard PPO

(Indemnity Plans)

s. the following human-to-human organ or tissue transplants (including charges for organ or tissue procurement), if the facility where the transplant is performed meets clinical standards for the procedure:

(1) heart; and
(2) liver; and
(3) heart/lung; and
(4) kidney; and
(5) cornea; and
(6) bone marrow transplants and peripheral stem cell support for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome;

(PPO Plans)

Category B includes:

(16) the following human-to-human organ or tissue transplants (including charges for organ or tissue procurement), if the facility where the transplant is performed meets clinical standards for the procedure:

- liver; and
- heart; and
- heart/lung; and
- kidney; and
- cornea; and
- bonemarrow transplants and peripheral stem cell support for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome;

The wording on booklet-certificate pages 2 and 3 (Basic and Standard Indemnity) and page 3 (Basic and Standard PPO) is:

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL

GH402 (SE) C0-5 Basic and Standard Indemnity and PPO

Covered Charges

(Indemnity Plans)

- the following human-to-human organ or tissue transplants (including charges for organ or tissue procurement), if the facility where the transplant is performed meets clinical standards for the procedure:

    - heart; and
    - liver; and
    - heart/lung; and
    - kidney; and
    - cornea; and
    - bone marrow transplants and peripheral stem cell support for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome.

(PPO Plans)

Category B includes:

- the following human-to-human organ or tissue transplants (including charges for organ or tissue procurement), if the facility where the transplant is performed meets clinical standards for the procedure:

    - heart; and
    - liver; and
    - heart/lung; and
    - kidney; and
    - cornea; and
    - bone marrow transplants and peripheral stem cell support for Hodgkin's aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome.

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

Recommendation No. 21:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect a complete list of covered organ transplants as required by Colorado insurance law.

In the Market Conduct examination for calendar year l998, the Company was previously cited for failure to include a complete list of organ transplants to be covered in the Basic or Standard Health Benefit Plan. The violation resulted in Recommendation # 23, that the Company revise its forms to include a complete list of transplant coverages in its Basic and Standard Health Benefit Plans. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue E18: Failure of the forms to provide benefits for covered services based on a provider's status as a family member.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) **Reimbursement of providers**
(a) **Sickness and accident insurance.**

(I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …
(II) The provisions of subparagraph (I) of this paragraph (a) shall apply:
(B) To all blanket and group sickness and accident policies issued, renewed, or reinstated on and after July 1, 1973.

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans and the policy and booklet-certificate for the GC 5000 Series plans reflect an exclusion that does not appear to be in compliance with Colorado insurance law in that it denies reimbursement for covered benefits to licensed providers who are members of an insured or dependent's immediate family.

The wording on the master policy page 13 (Basic and Standard Indemnity) and page 15 (Basic and Standard PPO) is:

PART IV – BENEFITS

Section B – Comprehensive Medical Expense Insurance

GC 552 (SE) CO-5

Article 9 – Limitations

Covered Charges will not include and no benefits will be paid for:

c. the services of any person who is in the Member's or Dependent's Immediate Family;

The wording on the booklet-certificate page 6 (Basic and Standard Indemnity) and page 8 (Basic and Standard PPO) is:

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL

GH 402 (SE) CO-5

Limitations

Comprehensive Medical Covered Charges will not include and no benefits will be paid for:

- the services of any person in your Immediate Family, or any person in your Dependent's Immediate Family;

The wording on the GC 5000 Series policy page GC 5013 CO-2 is:

PART IV – BENEFITS

Section B – Comprehensive Medical Expense Insurance, Page 26

Article 16 – Limitations

e. the services of any person who is in the Member's [or Dependent's] Immediate Family;

The wording on the GC 5000 Series booklet-certificate page GH 407 B CO-2 is:

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL EXPENSE INSURANCE

Limitations

Covered Charges will not include and no benefits will be paid for:

- the services of any person in your Immediate Family [or any person in your Dependent's Immediate Family];

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 22:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect that benefits may not be denied solely based on a provider's status (e.g. family member), as required by Colorado insurance law.

Issue E19: Failure of the forms to reflect correct benefits for inpatient well baby care.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8) and 10-16-109, C.R.S., states:

III. Rules

A. The form and content of the basic and standard health benefit plans, as appended to this regulation, shall constitute the basic and standard health benefit plans required for use in Colorado's small employer market pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2002

2002 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO
2002 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

Benefit Grid

PART B: SUMMARY OF BENEFITS

BASIC
INDEMNITY PLAN

10. MATERNITY a) Prenatal	50% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	50%

STANDARD
INDEMNITY PLAN

10. MATERNITY a) Prenatal	70% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	70%

	BASIC PPO PLAN IN NETWORK	BASIC PPO PLAN OUT-OF-NETWORK[1a]
10. MATERNITY a) Prenatal	70% (deductible does not apply)	50% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	70%	50%

	STANDARD PPO PLAN IN NETWORK	STANDARD PPO PLAN OUT-OF-NETWORK[1a]
10. MATERNITY a) Prenatal	80% (deductible does not apply)	50% (deductible does not apply)
b) Delivery & inpatient well baby care [7]	80%	50%

7 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans appear to reflect an incorrect description of inpatient well baby coverage as noted below:

An in-hospital newborn pediatric visit is included in the definition of well baby care; however, it is to be paid at the inpatient benefit level applicable to the plan type and subject to the deductible. The policy pages for the indemnity plans state under "hospital care of a newborn child" that a newborn is also eligible for a pediatric examination subject to the $10 per visit copayment. It also indicates this is described under Article 1B, Preventive Care Services, and appears to be describing the newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery. The policy pages for the PPO Plans do not reflect the $10 per visit copayment, but do indicate this coverage is described under Category D which is, Preventive Care Services.

The wording on policy page 8 (Basic and Standard Indemnity) and page 9 (Basic and Standard PPO) is:

PART IV – BENEFITS

Section B – Comprehensive Medical Expense Insurance

Article 3 – Covered Charges

GC 552 (SE) CO-5 (Basic and Standard Indemnity and Basic PPO)
GC 552 (SE) CO-4 (Standard PPO)

Indemnity Plans

o. obstetrical care and family planning services for:

(3) Hospital care of a newborn child. …A newborn shall also be eligible for a well baby newborn pediatric examination subject to the $10 per visit copayment described under Article 1B in this section;

PPO Plans

b. **Category B** includes:

(15) obstetrical care and family planning services for:

- Hospital care of a newborn child. …A newborn shall also be eligible for a well baby newborn pediatric examination as described under Category D in this section;

The wording on booklet-certificate page 2 (Basic and Standard Indemnity and PPO) is:

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL

GH 402 (SE) CO-5

Indemnity Plans

- obstetrical care and family planning services for:

- Hospital care of a newborn child.. …A newborn shall also be eligible for a well baby newborn pediatric examination subject to the $10 copayment described under Preventive Care in the SUMARY OF BENEFITS section;

PPO Plans

- obstetrical care and family planning services for:

- Hospital care of a newborn child. … A newborn shall also be eligible for a well baby newborn pediatric examination as described in Category D;

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan

Recommendation No. 23:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correct inpatient well baby coverage as required by Colorado insurance law.

Issue E20: Failure of the forms to reflect correct and complete coverage to be provided for home health care and hospice care services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers.

(a) **Sickness and accident insurance.**

(I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, *whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.* [Emphasis added.]

…

(8) **Availability of hospice care coverage.**

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state *clearly and completely the criteria for and extent of coverage for home health services and hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 4. Requirements for Home Health Services

C. Benefits for Home Health Care Services.

(2) The policy or certificate may contain a limitation on the number of home health visits, but no policy offered may provide for fewer than 60 home health visits in any calendar year.

Section 5. Requirements for Hospice Care

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

(3) The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:

(a) Bereavement support services for the family of the deceased person during the twelve month period following death, and in no event shall this maximum benefit be less than $1150.

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

D. Limitations and Exclusions.

Benefits for hospice care services shall be governed by policy or certificate limitations and exclusions, to the extent that such policy or certificate is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by this regulation. The insurer must notify the hospice in writing of any such limitation of benefits, and must do so within two business days of a request to determine if specific services are excluded or authorized under the coverage.

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans and the policy and booklet-certificate for the GC 5000 Series plans reflect an exclusion that does not appear to be in compliance with Colorado insurance law as it is unlawful to deny reimbursement for covered home health care services to licensed providers based upon the provider's status, e.g., residing in the home.

The wording on policy page 10 (basic and standard indemnity), page 12 (basic and standard PPO), is:

GC 552 (SE) CO-5 (basic and standard indemnity & basic PPO plans)
GC 552 (SE) CO-4 (standard PPO plan)
PART IV –BENEFITS

Section B – Comprehensive Medical Expense Insurance (basic and standard indemnity)
Comprehensive Medical Expense Insurance (basic and standard PPO)

Article 5 – Home Health Care

The general Comprehensive Medical limitations listed in this section will apply to Home Health Care. In addition, Comprehensive Medical Covered Charges will not include charges for:

b. the services of any person who normally lives in the Member's or Dependent's home;

The wording on booklet-certificate page 4 (basic and standard Indemnity), page 6 (basic and standard PPO), is:

GH 402 (SE) CO-5 (basic and standard Indemnity and PPO plans)

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL

Covered Charges

Home Health Care

The general Comprehensive Medical limitations listed in this section will apply to Home Health Care. In addition, Comprehensive Medical Covered Charges will not include charges for:

- the services of any person who normally lives in your home or Dependent's home;

The Company's master policy and booklet-certificate for the Basic and Standard Health Benefit Plans do not appear to correctly or completely reflect the criteria for and extent of coverage for home health services and hospice care in the following ways:

Incomplete

1. There is nothing reflected concerning the minimum number of home health visits to be allowed.

2. There is nothing reflected to indicate that there are twelve (12) benefits which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

3. There is nothing reflected concerning the two (2) exceptions (weekends and holidays) for obtaining advance authorization for short-term general inpatient (acute) hospice care of continuous home care during a period of crisis, for pain control or symptom management.

4. The section reflecting that the general limitations listed will apply to Hospice Care services is incomplete as it does not include that this is applicable to the extent that the policy is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by Colorado insurance law and that a hospice must be notified of any such limitation of benefits within two (2) business days of a request to determine if services are excluded or covered.

Incorrect

1. An incorrect maximum hospice per diem rate of $91 is reflected. The correct maximum hospice per diem rate as of February 1, 2001 was $100.

The wording on policy page 11 (basic and standard indemnity), page 14 (basic PPO) and page 13 (standard PPO) is:

GC 552 (SE) CO-5 (basic and standard indemnity & basic PPO plans)
GC 552 (SE) CO-4 (standard PPO plan)

PART IV –BENEFITS

Section B – Comprehensive Medical Expense Insurance (basic and standard indemnity)
Comprehensive Medical Expense Insurance (basic and standard PPO)

Article 6 – Hospice Care

Benefits for the following Hospice Care Services are payable the same as for any other sickness up to a maximum benefit of $91 per day for each insured person:

The wording on booklet-certificate page 5 (Basic and Standard Indemnity) and page 7 (Basic & Standard PPO) is

GH 402 (SE) CO-5 (basic and standard Indemnity and PPO plans)

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL

Covered Charges

Hospice Care

Benefits for the following Hospice Care Services are payable the same as for any other sickness up to a maximum benefit of $91 per day for each insured person:

2. An incorrect maximum bereavement support service amount of $1077 and an incorrect period of time for the services to be provided of three (3) months is reflected. As of February 1, 2001 the correct maximum benefit for this service was $1150 and the correct period of time for the service to be provided was twelve (12) months following death.

The wording on policy page 12 (basic and standard indemnity) and page 14 (basic and standard PPO) is:

GC 552 (SE) CO-5 (basic and standard indemnity & basic PPO plans)
GC 552 (SE) CO-4 (standard PPO plan)

PART IV –BENEFITS

Section B – Comprehensive Medical Expense Insurance (basic and standard indemnity)
Comprehensive Medical Expense Insurance (basic and standard PPO)

Article 6 – Hospice Care

j. Bereavement Services for the individual's Immediate Family and persons with significant personal ties to the individual during the three month period following the individual's death, up to a maximum benefit of $1,077.

The wording on booklet-certificate page 6 (Basic and Standard Indemnity) and page 7 (Basic and Standard PPO) is:

GH 402 (SE) CO-5 (basic and standard Indemnity and PPO plans)

DESCRIPTION OF BENEFITS

COMPREHENSIVE MEDICAL

Covered Charges

Hospice Care

- Bereavement Services for the individual's Immediate Family and persons with significant personal ties to the individual during the three month period following the individual's death, up to a maximum benefit of $1,077.

3. An incorrect lifetime maximum benefit of 30 days for care for a period of crisis, pain control, or symptom-management is reflected. This limitation was eliminated as of February 1, 2001.

The wording on policy page 12 (basic indemnity) pages 11 and 12 (standard indemnity), and page 14 (basic and standard PPO) is:

GC 552 (SE) CO-5 (basic and standard indemnity & basic PPO plans)
GC 552 (SE) CO-4 (standard PPO plan)

PART IV –BENEFITS

Section B – Comprehensive Medical Expense Insurance (basic and standard indemnity)
Comprehensive Medical Expense Insurance (basic and standard PPO)

Article 6 – Hospice Care

i. short-term general inpatient (acute) care or continuous Home Care for a period of crisis, pain control, or symptom-management when authorized in advance by the Hospice Care Team and, except for emergencies, by the Company, up to a lifetime maximum benefit of 30 days for each insured person;

The wording on booklet-certificate page 6 (Basic and Standard Indemnity) and page 7 (Basic and Standard PPO) is:

GH 402 (SE) CO-5 (basic and standard Indemnity and PPO plans)

DESCRIPTION OF BENEFITS
COMPREHENSIVE MEDICAL

Covered Charges

Hospice Care

- short-term general inpatient (acute) care or continuous Home Care for a period of crisis, pain control, or symptom-management when authorized in advance by the Hospice Care Team and, except for emergencies, by Us, up to a lifetime maximum benefit of 30 days for each insured person;

The Company's GC 5000 Series policy and booklet-certificate appear to incorrectly reflect two (2) benefits as being subject to the dollar limitation for hospice care benefits and Colorado insurance law indicates they are exclusive of and not to be included in the dollar limitation. Benefits for physical, occupational and speech therapies and nutritional counseling by a nutritionist or dietitian are subject to the policy's deductible, coinsurance and stoploss provisions, but are not subject to the dollar limitation for hospice care benefits.

The wording on policy page GC 5014 CO-2 is:

PART IV – BENEFITS

Section B (1) – Comprehensive Medical Expense Insurance (PPO), Page 25

Article 12 – Hospice Care

c. Benefits Payable

(2) Benefits for the following Hospice Care Services are payable the same as for any other covered Treatment or Service up to a maximum benefit for each insured person, of $100 per day and $9,100 per Hospice Care Benefit Period (the three-month period defined in (4) below):

(iii) physical, occupational, or speech therapy; and
(iv) nutrition counseling by a nutritionist or dietitian;

The wording on booklet-certificate page GH 407 A CO-2 is:

DESCRIPTION OF BENEFITS

COMPREHENSIVE MEDICAL, Page 9

Hospice Care

Benefits Payable

- Benefits for the following Hospice Care Services are payable the same as for any other covered Treatment or Service up to a maximum benefit for each insured person, of

  [$100] per day and [$9,100] per Hospice Care Benefit Period (the three month period defined below):

  - physical, occupational, or speech therapy; and
  - nutrition counseling by a nutritionist or dietician;

Form Number	Form Name
GC 500 SE Series	Master Policy for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GH 100 (SE)-1	Booklet-Certificate for the Basic Indemnity Health Benefit Plan Basic PPO Health Benefit Plan Standard Indemnity Health Benefit Plan Standard PPO Health Benefit Plan
GC 5000 Series	Group Medical Expense Insurance

Recommendation No. 24:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to reflect correctly and completely, the extent of coverage to be provided for home health and hospice care services as required by Colorado insurance law.

UNDERWRITING
RATING
FINDINGS

Issue F1: Failure, in some cases, to use the rates filed with the Colorado Division of Insurance.

Section 10-16-107, C.R.S., Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain, states:

> (2) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer has filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of the insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

Amended Regulation 4-6-7, Concerning Premium Rate Setting For Small Group Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-16-105(6.5), 10-16-105(7.2), 10-16-105(8)(f), and 10-16-109, Colorado Revised Statutes, states:

> Section 5. Premium Rate Setting
>
> A. Calculating Premium Rates Adjusted for Case Characteristics
>
> (1) Index Rate – Each carrier offering a health benefit plan to groups in Colorado shall develop a single index rate for all small group plans it offers. This single index rate is identical to a community rate for the company's universe of small group plans offered for new issue or renewal. It should be calculated using the experience for all small group plans. *The premium rate charged during a rating period, applicable to all small employers, shall be based upon this index rate, adjusted for case characteristics and coverage as allowed in this Section 5.* [Emphasis Added]

It appears that the Company is not in compliance with Colorado insurance law in that it failed to implement some of the items included in its small group rate filing to be effective December 1, 2002, until January 2003. As a result, the rates charged for all groups that renewed during December 2002, were higher than the filed rates for the following items:

> Future Trend, Desired Loss Ratio and Area Factor

The Future Trend filed in the December 2002 rate filing was 20%, however, the reduction from 24% to 20% was not made in the Company's system until January 2003. The Desired Loss Ratio was changed from 0.748 to 0.764. Area Factors for Summit, Park, Pitkin, Gunnison and Lake counties were filed as 1.21, but should have been 1.27. The area factors of 1.27 were implemented. The Area Factors represented a 4.5% decrease in premium.

The Future Trend and Desired Loss Ratio error would have resulted in a 6% lower premium for all Colorado Small Group plans renewing or issued in December 2002. The Company issued only four (4) New Business plans in 2002 and none of these were effective in December; however there were three (3) renewal plans in the systematically selected sample of fifty (50) Renewal Business plans that were

affected. The Company identified twenty-two (22) additional Colorado small group renewals during 2002 that were affected by failure to implement this change as of the effective date filed with the Colorado Division of Insurance.

Recommendation No. 25:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107, C.R.S. and Amended Regulation 4-6-7. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that filed rates are used as of the effective date stated in its filings with the Division of Insurance to ensure compliance with Colorado insurance law.

UNDERWRITING APPLICATIONS FINDINGS

Issue G1: Failure to display a correct disclosure statement concerning guaranteed issue on renewal letters.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

> III. RULES
>
> E. 1. The following disclosure statement, prominently displayed in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except the Colorado Comprehensive Health Benefit Plan Description Form pursuant to Colorado Division of Insurance Regulation 4-2-20), small employer application forms, *and small employer renewal notices*, and on all written refusals to insure which are related to health coverage for a business group of one. [Emphasis added.]
>
> "Colorado insurance law requires all carriers in the small group market to issue any health benefit plan it markets in Colorado to small employers of 2-50 employees, including a basic or standard health benefit plan, upon the request of a small employer to the entire small group, regardless of the health status of any of the individuals in the group. Business groups of one cannot be rejected under a basic or standard health benefit plan during open enrollment periods as specified by law."

The disclosure used by the Company on the employer renewal notice material does not appear to be correct in that it indicates that only the Basic or Standard Health Benefit Plans are guaranteed issue regardless of the health status of any of the individuals in the group. Colorado insurance law requires carriers in the small group market to guarantee issue any health benefit plan marketed in Colorado to small employers of 2-50 employees, regardless of the health status of any of the individuals in the group.

The wording used by the Company in its renewal letters in 2002 was:

> **COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE A BASIC OR STANDARD HEALTH BENEFIT PLAN UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN.**

Form Name	Form Number	
Renewal Letter	GP 47738-1	10/2000 8/2001
	GP 47738-2	8/2001
	GP 47738-3	5/2002
	GP 47738-4	5/2002
	GP 47738-5	5/2002

RENEWAL BUSINESS APPLICATION FILES

Population	Sample	Number of Exceptions	Percentage to Sample
489	50	50	100%

Recommendation No. 26:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that correct and complete wording is used in the required guaranteed issue disclosure statement as required by Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure to offer conversion coverage to eligible members of terminated groups.
(This was prior issue H1 in the findings of the 1998 final examination report).

Section 10-16-108, C.R.S., Conversion and continuation privileges, states:

(4). **Special provisions for small group health benefit plans.**

(a) Effective January 1, 1995, each small employer carrier shall, upon termination of a group policy by the carrier or employer for reasons other than replacement with another group policy or fraud and abuse in procuring and utilizing coverage, offer to any individual the choice of a basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.

Regulation 4-6-9, Concerning Conversion Coverage, promulgated under the authority of Sections 10-1-109(1) and 10-16-109, C.R.S., states:

Section 4. Definitions

A. "Conversion coverage" means that coverage provided by carriers pursuant to Sections 10-16-108(1)(c), 10-16-108(2)(d), and 10-16-108(4), C.R.S.

Section 5. Choice of Basic or Standard Health Benefit Plans

A. All persons entitled to elect conversion coverage pursuant to Sections 10-16-108(1)(c), or 10-16-108(2)(d) and 10-16-108(4), C.R.S., shall be offered a choice of the basic or standard health benefit plans only. (The basic and standard health benefit plans and rules for their implementation are described in Colorado insurance regulation No. 4-6-5, C.C.R.)

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 316 small group files that had been cancelled or non-renewed during the examination period. It appears that the Company is not in compliance with Colorado insurance law in that eleven (11) of the files appear to have been terminated for reasons that would require the offer of the choice of a basic or standard health benefit plan as conversion coverage, and did not include any indication that the coverage had been replaced. No documentation was provided that conversion coverage was offered for any of these eleven (11) files.

CANCELLED-NON-RENEWED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
316	50	11	22%

Recommendation No. 27:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-108, C.R.S., and Regulation 4-6-9. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that conversion coverage is offered to all eligible members of terminated groups as required by Colorado insurance law.

In the Market Conduct examination for calendar year l998, the Company was previously cited for failure to offer the Basic or Standard Health Benefit Plan to employees of terminated small employer policies. The violation resulted in Recommendation # 32, that the Company develop procedures to ensure that terminated employees are offered the choice of a Basic or Standard Plan upon termination of the group contract or coverage under the group contract. Failure to comply with the previous recommendation and order of the commissioner may constitute a violation of Section 10-1-205, C.R.S.

Issue H2: Failure, in some cases, to issue Certificates of Creditable Coverage.

Amended Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage For Pre-existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

II. Purpose And Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage when determining exclusions for pre-existing conditions as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 1999 amendments to this regulation is to update the regulation as part of the Executive Order Review Process (Executive Order D0004 97).

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

    a. Those exceptions specifically enumerated in this regulation; and

    b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c);45 C.F.R. 146.115; 45 C.F.R. 146.117: 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b) (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan's duty to provide certificates of creditable coverage to insureds, special enrollment periods, the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later amendments to, or editions of, the above-referenced regulations. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated regulations which begins in Volume 62, number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

It appears that the Company's automated system for producing certificates of creditable coverage in 2002 did not guarantee that certificates were issued in all applicable instances. The system compared the most recent effective dates in both the employee record and claim benefit record. If the employee record effective date was older than the oldest claim benefit record effective date, the system did not think there was medical coverage on the group and a certificate of creditable coverage was not produced. The Company indicated it has implemented a change in the logic of the system, which would prevent this from happening, effective August 15, 2003.

Recommendation No. 28:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Certificates of Creditable Coverage are issued to all employees terminating medical coverage as required by Colorado insurance law. It is also recommended that the Company determine which insureds did not receive Certificates of Creditable Coverage during 2002 through August 14, 2003 and provide them when the determination is made.

CLAIMS
FINDINGS

Issue J1: Failure, in some cases, to pay, deny or settle clean electronic claims within thirty (30) days, clean non-electronic claims within forty-five (45) days, and except where fraud is involved, all claims within ninety (90) days.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be due on the ninety-first day after receipt of the claim by the carrier.

Paid and Denied Claims Received Electronically in 2002 Exceeding 30 Days

Data provided by the Company indicated a population of 15,990 paid and denied small group claims received electronically in 2002. The examiners identified 274 claims from this population as taking over thirty (30) days from date of receipt to process. A systematically selected sample of 100 claims was taken from these 274 files. Thirteen (13) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
274*	100	13	13%

(*2% of all electronic claims)

Paid and Denied Claims Received Non-Electronically in 2002 Exceeding 45 Days

Data provided by the Company indicated a population of 20,998 paid and denied small group claims received non-electronically in 2002. The examiners identified 1,035 claims from this population as taking over forty-five (45) days from date of receipt to process. A systematically selected sample of 100 claims was taken from these 1,035 files. Forty-one (41) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time frame.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
1,035*	100	41	41%

(*5% of all non-electronic claims)

Paid and Denied Claims Received in 2002 Exceeding 90 Days

Data provided by the Company indicated a population of 32,355 paid small group claims and 4,633 denied small group claims received in 2002. The examiners identified 210 claims from this combined population of 36,988 as taking over ninety (90) days from date of receipt to process. None of these 210 claims appeared to involve fraud. These claims do not appear to have been paid, denied or settled as required by Colorado insurance law with respect to the ninety day time frame.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
210*	N/A	210	100%

(*<1% of all claims)

Recommendation No. 29:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all clean electronic claims are paid, denied or settled within thirty (30) days; all clean non-electronic claims are paid, denied or settled within forty-five (45) days, and except where fraud is involved, all claims are paid, denied, or settled within ninety (90) days as required by Colorado insurance law.

Issue J2: Failure, in some instances, to process claims accurately.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(f) Unfair discrimination states:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; . . .

GROUP PAID CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Population
32,355	100	9	9%

GROUP DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Population
4,633	100	4	4%

Systematically selected samples were chosen for review of processing from the population of group claims received from January 1, 2002 through December 31, 2002. The populations, sample sizes, number of exceptions and percentages to the sample are reflected above.

It appears that the Company is not in compliance with Colorado insurance law in that nine (9) paid claims, and four (4) denied claims do not appear to have been processed correctly.

Recommendation No. 30:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its claims processing quality controls to ensure that all claims are investigated properly to determine the proper allocation of benefits and to eliminate unnecessary delays in payment as required by Colorado insurance law.

Issue J3: Failure, in some instances, to pay late payment penalties on claims.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

The Company indicated that it made no payment of late payment penalties during the first six months of 2002. This does not appear to be in compliance with Colorado insurance law that required during all of 2002, a late payment penalty to be paid in an amount equal to ten percent (10%) of the total amount ultimately allowed on the claim in applicable instances.

Recommendation No. 31:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that late payment penalties are paid on all applicable claims as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
transplants. (This was prior issue E11 in the findings of the 1998 final examination report).		
Issue E18: Failure of the forms to provide benefits for covered services based on a provider's status as a family member.	22	72
Issue E19: Failure of the forms to reflect correct benefits for inpatient well baby care.	23	76
Issue E20: Failure of the forms to reflect correct and complete coverage to be provided for home health care and hospice care services.	24	84
UNDERWRITING - RATING		
Issue F1: Failure, in some cases, to use the rates filed with the Colorado Division of Insurance.	25	87
UNDERWRITING - APPLICATION FILES - FINDINGS		
Issue G1: Failure to display a correct disclosure statement concerning guaranteed issue on renewal letters.	26	90
UNDERWRITING - CANCELLATIONS/NON-REN/DECLINATIONS		
Issue H1: Failure to offer conversion coverage to eligible members of terminated groups. (This was prior issue H1 in the findings of the 1998 final examination report).	27	93
Issue H2: Failure, in some cases, to issue Certificates of Creditable Coverage.	28	95
CLAIMS – FINDINGS		
Issue J1: Failure, in some cases, to pay, deny or settle clean electronic claims within thirty (30) days, clean non-electronic claims within forty-five (45) days, and except where fraud is involved, all claims within ninety (90) days.	29	99
Issue J2: Failure, in some instances, to process claims accurately.	30	100
Issue J3: Failure, in some instances, to pay late payment penalties on claims.	31	101

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